IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF NORTH CAROLINA
CHARLOTTE DIVISION

Civil Action No. 3:22-cv-0191

KANAUTICA ZAYRE-BROWN,)
)
Plaintiff,)
)
v.)
)
THE NORTH CAROLINA)
DEPARTMENT OF PUBLIC)
SAFETY, et al.,)
)
Defendants.)
)

30(b)(6) DEPOSITION OF ARTHUR CAMPBELL, M.D.
THE NORTH CAROLINA DEPARTMENT OF PUBLIC SAFETY

(Taken by plaintiff.)

Raleigh, North Carolina

April 18, 2023, 9:30 a.m.

Reported By:
SUSAN GALLAGHER, CA CSR, CVR-CM

through memorandums of agreement and other methods to make sure that the offenders can receive the care that they need, and that's the full spectrum. There is nothing that's excluded or not included in it that.

Q Okay. Does DPS require that the healthcare decisions regarding individuals based on their own individualized circumstances?

A Yes, ma'am.

Q Do decisions for each individual to be based on individual determinations?

A Yes, ma'am.

Q Does DPS permit DPS healthcare providers' personal views to factor into the delivery of health and wellness services to people in custody?

A No, ma'am.

Q Does DPS permit DPS healthcare providers' political views to factor into the delivery of health services to people in their custody?

A No, ma'am.

Q I now want to have marked as Exhibit 3 a policy entitled "Health and Wellness Services Organization."

(Exhibit 3 marked for identification.)

BY MS. MAFFETORE:

Q Do you recognize this policy?

A Yes, ma'am.

Q And what is this policy, broadly speaking?

A So this talks about the overarching philosophy and the structure and authorities within -- they call it health and wellness here. That's since changed since we're the Department of Adult Corrections. So the new name for this is the Division of Comprehensive Health Services, but essentially the same policy carries forward.

Q And when would the policy have shifted title?

A When DPS made the transition to DAC, which was in the past 60 days, roughly.

Q Okay. And you've seen this policy before today; correct?

A Yes, ma'am.

Q Who at DPS is responsible for drafting this policy?

A So this would be -- under the current structure will be the deputy secretary for Comprehensive Health Services.

Q Okay. And under the previous structure?

A It would have been the director of Health and Wellness.

Q So is that or was that at the time Gary Junker?

A It was and still is.

Q Does Gary Junker have a -- his title is

slightly different now; is that correct?

A Correct. He's now the deputy secretary.

Q Did you have any involvement in drafting this policy?

A No, ma'am.

Q Have you ever been asked to contribute to any revisions of the policy?

A No, ma'am.

Q If you could please look at page 1 of this exhibit, Section 2C at the bottom, do you see a portion that says, "In support of DOP's mission statement, health and wellness professionals shall promote excellence, provide community-consistent cost effective quality healthcare throughout our system."

Did I read that accurately?

A Yes, ma'am.

Q What does DOP mean by "community consistent healthcare"?

A So, again, they -- well, we are expected to provide our services that are consistent with standards of care or community practice. So there is a little bit of a distinction between what's the standard of care as opposed to following clinical practice guidelines, but that's the consistency there. So we need to be consistent with what the community is doing.

In other words, offenders should receive the exact same care they would get if they were on the outside.

Q Okay. You mentioned just now some distinction between standards of care and clinical guidelines. Could you elaborate on that?

A Sure. Standard of care is, quite frankly, more of a legal term than a medical term. So in the medical community, what we rely on and what the vast majority of all of the professional medical societies publish are clinical practice guidelines. They don't call them standard of care, per se.

So the best medical definition of standard of care would be the diagnostic or treatment procedures that a clinician should follow in treating a particular patient, illness, or a particular clinical circumstance. Legally it has a little bit different twist, and my interpretation of a legal definition of that would be that it's, how would the average the prudent provider provide care for that specific patient in those circumstances, or how would a similarly qualified and trained clinician provide care for a particular patient in those exact clinical circumstances.

Q Okay. Now, when you say that folks that are incarcerated should receive the same care in prison as

if they were in the community, what community are you looking to to determine what constitutes community consistent healthcare?

A So in the broad context, it's outside the prison.

Q So would that be nationwide?

A Well, not specifically because, again, states have -- for instance, you know, Medicaid is a state-run program. So states have variations in what their individual state provides and covers. Within the context of medical care though, the care should be the same. You know, if it is truly standard of care, it's going to be fairly consistent across the country.

Q Okay. So if I'm understanding your testimony correctly, in certain circumstances the community against which you're judging would be the state, but generally speaking it is nationwide?

A Correct.

Q Okay. Where does the definition or the explanation you just described, "community consistent healthcare," come from?

A I don't know what the origins of that is.

Q How did you come to be familiar with that?

A Again, by reading these policies and understanding what the department's policy is and how

we are supposed to take care of these offenders. That's where I became aware of what that standard is.

Q Does DPS provide training to its health services staff members regarding the meaning of community consistent care?

A I don't know if there's any specific training for that. You obviously review policies and procedures, and you have orientation when you arrive at the organization, and that's part of that, but I don't know if there's a specific training dedicated to this particular aspect of that.

Q Okay. From your understanding or from DPS's understanding, is medically necessary care the same as community consistent care?

A Generally, yes.

Q You said "generally, yes." Are there circumstances when that is not the case?

A Well, I think the difference would be in the community, individuals can pay for care that may be elective. Whereas, in the prison, we are responsible for providing that care.

Q I'm not sure I understand -- I'm not sure I understand that answer. So that's a situation where medically necessary care and community consistent care would not be similar is where elective procedures are

involved?

A Well, not just elective, but individuals in the community may not have, for instance, insurance. So it's different here. We cover these individuals for the care that's provided in the prison.

Q Okay. How does DPS define "medical necessity"?

A That's a big answer. So in its simplest terms, when you look at medical necessity, it's probably best defined as a procedure that is reasonable and appropriate for a particular individual, really, to either protect their life, to prevent significant disability or illness, or to prevent significant pain and suffering. That is a very broad definition of medical necessity, and quite honestly, it's been through a lot of subjectivity, and so within prisons we need to be a little more deliberate in how we define that.

So what we need to be sure in prisons is that every officer that has a similar clinical circumstances that has a case submitted for review or a clinical condition, it's evaluated in the exact same way as objectively as possible as any other offender in the prison, and that's for any medical condition that they may see.

In my interpretation of medical necessity, in

order to get after that and to be able to come up with a more clear understanding of what that means, you have look at what factors would you see with medical necessity that could be attributed to that, and there's really three broad ones, I think, that fall under that category.

First is a risk-benefit analysis. Second is standard of care, and third is evidence based medicine, and I can certainly talk in more detail about each of those.

So as we look at a particular case or circumstance, those are the broad criteria we need to use to evaluate that. With risk-benefit analysis, it's important to note that this is by far the most critical piece of that evaluation. What that means is that you have to look at that particular patient and those particular circumstances and their clinical condition, and you need to determine whether the proposed treatment, what would be the impact if you were to not perform that procedure as opposed to performing the procedure for the offender. So you balance the risk of performing the procedure versus the potential risk of not performing that procedure, and what is the outcome of that, and that involves, again, a very individualized review of that particular patient and

those particular circumstances, and I think one of the things about that balance is that you cannot perform analysis without doing that individualized review of that case, and that's to your other question you asked about, that individualized review. So we do that.

So, for instance, if a procedure is proposed and you know the potential treatment for that, you look at that particular patient, those circumstances, and determine whether that procedure is appropriate and it's going to do those things I mentioned. Is it going to protect their life? Is it going to prevent significant illness or disability, and is it going to prevent significant pain and suffering? And that's how you do that risk-benefit analysis.

Q So I just have one follow-up regarding preventing significant pain and suffering. Is your understanding that emotional pain and suffering is also relevant to whether or not something is medically necessary?

A Yes, ma'am.

Q Psychological pain and suffering?

A Yes, ma'am.

Q And I believe a moment ago when you started explaining this to me, you said, "at least in my view," and I just want to be clear we're in the 30(b)(6)

portion of your deposition so I'm asking for DPS's position. Is your understanding that everything you just explained to me is DPS's position?

A No. So I think that DPS does not have a medical necessity definition, per se, or DAC.

Q So where did the definition of medical necessity as you just explained to me come from?

A Well, I'm thought you were asking my opinion of that. I probably should have not answered that, but that's --

MR. RODRIGUEZ: It was asked in the context of the 30(b)(6), and your response was in the context of your understanding of that as the representative, and then I think you clarified that it is not written in a policy, a departmental policy.

THE WITNESS: Correct.

BY MS. MAFFETORE:

Q And that's your understanding. So is that the definition that you use acting as medical director for DPS, what you just explained to me?

A The medical necessity for DPS would be what I described initially, the generally accepted medical definition of medical necessity. So that first thing I told you where it's basically those things that prevent death, significant illness, and disability. That is

the accepted standard, really, everywhere for what medical necessity is.

Q So you mentioned certain factors that are taken into account regarding medical necessity. Does DPS ever take into consideration the cost of a procedure when it's considering medical necessity?

A No.

Q How about security?

A Security is always considered in every context in our setting.

Q So it's considered a medical necessity determination?

A It's not a medical necessity determination, no, but security's always a determination.

Q Okay. How about logistics?

A Again, not for medical necessity, if that's what you're asking.

Q What about the ability to provide postoperative care?

A Again, not for medical necessity.

Q Is your interpretation as medical director on behalf of DPS of medical necessity the same for all DPS decisions about the provision of, for example, mental health care?

MR. RODRIGUEZ: Object to speculation.

You can answer.

THE WITNESS: It's universal when it relates to health care, regardless of the type of healthcare.

BY MS. MAFFETORE:

Q So also all medical care, all sorts of care?

MR. RODRIGUEZ: Same objection. Speculation.

You can answer.

THE WITNESS: Yes.

BY MS. MAFFETORE:

Q And in evaluating the request from someone in DPS custody for healthcare services, is there any kind of care where DPS would consider an individual's legal history in making a medical necessity determination?

A No, ma'am.

Q Is there any situation where DPS would consider an individual's criminal record in making a medical necessity determination?

A No, ma'am.

Q Is there any instance where DPS would consider an individual's disciplinary history or history of interactions in a medical necessity determination?

A No, ma'am.

Q If you to turn to page 2 of Exhibit 3, if you'll look at Section 2G5, it states there that "one of the goals of health and wellness is to engage in

sound healthcare practices that meet an acceptable standard of care"; correct?

A Correct.

Q So I think that you started to get into this when you were talking about medical necessity, but if you could get into it now, what constitutes an acceptable standard of care according to DPS?

A So, again, within DPS we rely on the same things I mentioned, which are clinical practice guidelines, and that is across the board what we rely on for standard of care.

Q What are the sources of those clinical practice guidelines?

A They will vary. It can be from the individual professional medical associations and societies. We often develop our own clinical practice guidelines specific for our individual setting. Each one of those references the pertinent medical society clinical practice guidelines, and we'll adapt those as needed for the prison environment.

Q Are there any circumstances where DPS would not look to individual medical associations and societies for clinical guidelines?

MR. RODRIGUEZ WITNESS: Object to speculation.

You can answer.

THE WITNESS: No, ma'am.

BY MS. MAFFETORE:

Q Okay. So on the same page of this exhibit, Section 2H, it states that "the provision of treatment regarding clinical decisions that involve health and wellness providers are the sole responsibility of the managing health and wellness practitioner and are not reversed by non-clinicians."

Did I read that correctly?

A Yes, ma'am.

Q What does DPS mean by this?

A So it means that medical decisions are made by medical authorities within the prison.

Q Okay. How does DPS define "clinician"?

A It is a licensed independent provider. So it's a provider who is credentialed to practice within our healthcare system.

Q So you said is a licensed health provider. What degrees of licensure does that encompass?

A So it can be family nurse practitioners, physician assistants, and physicians.

Q Anyone else?

A No.

Q Would a mental health care provider be considered a clinician?

A Yes.

Q And at what levels of medical health -- or mental health licensure would be considered a clinician?

A Licensed clinical social workers, psychologists, obviously psychiatrists are physicians, but they all fall in that same spectrum.

Q Does DP's definition of clinician have anything to do with the degree of patient contact a medical provider or mental health care provider has?

A No. They're licensed or credentialed based on their qualifications.

Q Okay. So if somebody holds a licensure within DPS but is in a position where they do not see patients at all, that person is still considered a clinician based on DPS's definition of clinician?

A Yes, ma'am.

Q Who, if anyone within Health and Wellness Services, would not be considered a clinician by DPS?

A So the registered nurses, the LPNs, the certified nursing assistant, the certified medical assistants. There are lots of administrative staff, both budgetary and accounting. The section is very large and includes not only clinical folks, but clinical support folks as well. There's respiratory

therapists. There's a lot of folks that are not considered credential providers.

Q Is there anyone outside of health and wellness who would be considered a clinician by DPS?

A No.

Q According to DPS, why shouldn't medical decisions be reversed by non-clinicians?

MR. RODRIGUEZ: Object to speculation.

You can answer.

THE WITNESS: Again, the only folks trained and qualified to make those medical decisions and recommendations are medical providers.

BY MS. MAFFETORE:

Q Are there any circumstances when DPS considers it appropriate for decisions to be reversed by non-clinicians?

MR. RODRIGUEZ: Objection to speculation.

You can answer.

THE WITNESS: Not that I'm aware of, no.

BY MS. MAFFETORE:

Q If you could turn to page 5 of this exhibit and look with me to Section -- you can't see a 3 on this page, but it's 3H. That section states, "Medical services are provided under the direction of the medical director/chief medical officer who maintains

responsibility for the quality of medical services provided to offenders."

Did I read that correctly?

A Yes, ma'am.

Q The medical director/chief medical officer referred to in this policy is currently you; correct?

A Yes, ma'am.

Q Still on page 5, still under H, Section 1 states that "services are provided in accordance with a professionally identified evidence-based clinical decision support resource."

Did I read that correctly?

A Yes, ma'am.

Q What is a clinical support -- clinical decision support resource?

A So it references, again, back to what I told you, the clinical practice guidelines, the pertinent medical societies, all of those entities provide input into what's ultimately our clinical practice guidelines, the way we practice medicine within the prisons.

Q So are there different resources based on different conditions?

A I'm not sure I understand the question. I think that any pertinent medical literature is going to

be appropriate to be considered when you're considering medical problems. So whether that's using resources such as UpToDate or whether it's relying on, you know, medical societies and those things.

Q Okay. So just to clarify on my end, a clinical decision support resource is not something that DPS drafts, essentially, to provide to clinicians as a resource?

A No, ma'am.

Q Okay. My understanding of your testimony is that the, sort of, wide variety of sources related to specific conditions, documents from medical societies, various research, all of that is considered by DPS to be a clinical decision support resource. Am I understanding correctly?

A Yes, ma'am.

Q In H-1, when DPS says "professionally identified," by whom?

A So, again, I think it goes back to what I said, is that you rely on medical societies and organizations that are recognized. So in other words, they're well recognized entities in the medical community.

Q Is anybody within DPS Health and Wellness Services responsible for vetting which sources are credible enough to be utilized as a clinical decision

support resource?

A No, ma'am. I think that the reason they're licensed as providers is we expect them to conduct that analysis as they would in accordance with their credentials.

Q So what materials can be relied upon is left up to the discretion of the individual provider?

A Correct, assuming it doesn't violate any policies and procedures within the department.

Q How would the department know if the selection of resources to rely on violated the policies of the department?

A Probably would not know until, you know -- I can't even think of an example where that would be the case, but -- yeah. I can't think of an example right now.

Q And that same section that we're looking at, what does DPS mean by "evidence based"?

A So, again, that's critical. What you want to show is that the research that you're relying on, the decisions you make in developing clinical practice guidelines, are on based on the best available research that has been evaluated over time longitudinally, that's been studied very frequently and reproducible across, you know, the medical community.

Q How do you determine if a resource meets the criteria that you just described?

A So, again, I think that you can look to the professional medical organizations that I talked about, and they're going to reference a lot of those, and I so I think you're already starting with reliable sources when you do your analysis.

Q So you generally consider those professional medical associations to be reliable?

A Yes, ma'am.

Q You can set that aside for now. Actually, I don't think we'll come back to that.

Does DPS facilitate surgery for those in its custody with outside specialists?

A Yes, ma'am.

Q How do DPS facilities typically coordinate the logistics of surgical procedures to be performed on those in custody that will be performed by outside specialists?

A The logistics?

Q Yes.

A So the logistics of -- so there's a referral that's made, just like happens anywhere else in the community. There's a -- the primary care provider will make a referral, in this case, to a surgical

it needs to be a DOT medication, direct observation therapy. So there are several examples where depending on the medication there may need to be some changes to how they are prescribed.

Q Are there specific conditions for which medication must always be approved through the physician review process?

A There is no conditions that I'm aware of. It's generally based on the medication itself.

Q Okay. Understood. Is there a difference in the approval process based on whether or not a condition is considered chronic versus acute?

A Not with the initial approval, but we do have what's called a MRTS system. So for a chronic condition, those medications are automatically refilled up to a period of time before that individual has a reevaluation.

Q Okay. How does DPS determine whether a condition is chronic?

A So we have designated what we consider to be chronic diseases or illnesses.

Q So those are designations that are standard and not specific to an individual?

A Correct. They're based on the condition.

Q Does DPS consider gender dysphoria chronic or

acute?

A It's a chronic condition, but not all transgender or gender dysphoric patients are on medications, obviously.

Q If somebody is on, for example, hormone therapy to treat their gender dysphoria, would that fall under the chronic and thus automatically renew, or would it -- or not?

A No. Because when you're treating someone for, in this case I assume for hormonal replacement, you need to monitor levels. So you don't want to automatically refill medications without checking the levels. So that will apply to a lot of conditions. Individuals that are on anticoagulants, if that anticoagulant requires surveillance, then that won't be an automatically refilled medication. It needs to be monitored accordingly.

Q So my understanding is if it's chronic, it's refilled automatically, but if it's not chronic, there essentially needs to be another UR in order for that person to continue on that medication if that's what's necessary?

A Generally, yes. Again, it depends on -- these are very medication-specific questions. So it's going to depend on whether there's -- thyroid's another

example. So if you're giving Synthroid to a patient, you need to monitor their TSH levels. So you don't want to just continue to refill that medication without monitoring that. So at each of those intervals, you'll need to enter a new prescription.

Q If DPS is unable to coordinate the monitoring that is necessary before a UR expires, does that medication continue in the interim?

MR. RODRIGUEZ: Objection to form.

You can answer.

THE WITNESS: So, again, that's going to be a clinical decision by the provider. So if a medication is about to run out and we haven't had labs or whatever surveillance is necessary performed, then that individual provider, the primary care provider, will need to make a decision, and it will be a risk-benefit analysis like we've talked about before, to determine whether we continue the current dose while we await those labs. If we hold the dose depending on the medication until we get the labs, if there's some clinical reason to believe that it's not an appropriate dose, then we can hold it. So, again, it's a very specific, individualized determination that's made.

BY MS. MAFFETORE:

Q If a UR for a specific medication has expired,

will a prisoner be able to receive that medication?

A Not once the order has expired, no.

Q Okay. So if a physician does not take some action on behalf of the prisoner before the UR expires, that prisoner just won't receive that medication while waiting for labs; is that right?

A I mean, theoretically that could happen. We also put some personal responsibility on the offenders as well to inform us that they need a refill of their medication. So there are fall backs.

Q If the medication is not a carry-on-person medication, how would the prisoner be able to tell whether or not their medication was about to expire?

A So they will know when their last prescription was, and they're informed what the duration of the prescription is when they receive the prescription. So they'll know they were prescribed 60 days, 90 days of their medication.

Q If somebody's given medication, it's not carry-on-person, they're given medication once every two weeks and it's administered to them and the UR order is for, for example, six months, is it still the responsibility of the offender to know when that prescription would expire and need to seek physician approval for a new prescription?